Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST
PO BOX 890008
HOUSTON TX 77289

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-12-2852-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 15

MFDR Received Date
MAY 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…A copy of the CCH held on November 10, 2011, was provided wherein it indicated that the accepted compensable injury is a sprain/strain to the left knee and a left knee medical meniscus tear… The CCH disclosed other exclusions to the accepted compensable injury, but did not once did it reject the sprain/strain to the left knee. Therefore, the extent issue only relateds to the diagnosis of the sprain/strain of the ankle, which HealthTrust admits was incorrect and not accepted."

Amount in Dispute: $29,740.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS maintains its denial of services billed for 05/13/2011 – 11/29/2011 as a peer review completed 04/04/2012 by Dr. Robert Holladay identified that the chronic pain management program was not causally related to the effects of the 11/30/2009 work event."

Response Submitted by: ESIS South Central WC Claims, PO Box 6563, Scranton, PA 18505

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2011 May 20, 2011	CPT Code 90806	$295.12	$0.00
October 06, 2011 through November 29, 2011	Chronic Pain Management Program	$29,445.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §134.204 sets out the procedures for reimbursement for Workers' Compesnation Specific Services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - (219) – Based on extent of injury.
   - 1 – (219) – Based on extent of injury.

Issues

1. Has the extent of injury issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." The services in dispute were denied, in part, due to an unresolved extent of injury issue.

   A contested case hearing was held on October 10, 2011, with the record closing on November 2, 2011. On November 9, 2011 The Hearing Office issued a Decision and Order on the extent of injury. According to the Hearing Officer's decision, the Carrier has accepted a sprain/strain to the left knee and a left knee medial meniscus tear. Claimant had surgery to his left knee on February 22, 2010. The Decision goes on to state that the compensable injury sustained on November 30, 2009 does not extend to and include a sprain/strain to the left ankle, chronic tendonosis of the right ankle, a Baker's cyst to the left knee, an old bucket tear, patellar chondromalacia, an anterior cruciate ligament tear and posterior cruciate instability, a recurrent medial meniscus and lateral meniscus tear and internal degrangement of the left knee, Chronic Regional Pain Syndrome of the left lower extremity, and/or depression and anxiety.

   Review of the medical bills show that the diagnosis billed were 1. 844.9 – Sprain and strain of unspecified site of knee and leg and 2. 845.00 – Unspecified site of ankle sprain and strain. The requestor has billed for the compensable injury of sprain and strain of knee and leg; therefore, the disputed services will be reviewed in accorandace with Division rules and statutes.
2. In accordance with 28 Texas Administrative Code 133.307(c)(2) The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute. Review of the submitted documentation finds that the requestor did not submit copies of any medical records for review. No documentation was found to support the services as billed; as a result the amount ordered is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 18, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.